

Los Angeles County Department of Mental Health Stipend Program MFT Employment Verification Form

This Employment Verification Form is to be completed by the employer and submitted to: **MFT Stipend Program**, **Phillips Graduate Institute**, **c/o Jose Luis Flores**, **M.A.**, **19900 Plummer Street**, **Chatsworth**, **CA 91311**. The first page of the form is to be completed at initial hire, and the second page at the completion of 12 months full time employment. Only forms with original signatures are accepted.

Employee Information			
Full Name:			
Last	First	٨	1.1.
Address: Street Addre	ss	A	Apartment/Unit #
City		State Z	ZIP Code
Home Phone: (Alternate Phone: ()	
E-mail Address:			
Birth Date:	Social Security Number:		
I understand I can be penalized by law, and will be required to repay the educational stipend awarded if I misrepresent or purposely give false information on this form.			
Employee Signature:	Dat	te:	
Employment Information – Initial Hire Date			
What position does this employee hold?			
Number of hours per week the employee works?			
What is the start date of continuous employment for this employee?			
Does employee have bilingual capacity?			
Name of Agency/Progra Is this position within Specialized Foster Care MHSA Funded? Please	e, or		
Service Area (SPA) who employee provided care			
Name of Authorized Ag Representative:	ency	Title:	
Business phone #:	Email Address:		
I certify that the information I have given on this form is true and correct. I understand that purposefully providing false information on this form may lead to legal penalty and the forfeiture of stipend financial aid for the employee.			
Signature:	C	Oate:	
DO NOT COMPLETE THIS SECTION – For MFT Stipend Program/Phillips Graduate Institute use only.			
Verified by:	Date	:	



Verified by:

Los Angeles County Department of Mental Health Stipend Program MFT Employment Completion Form

Employment Information – 12 Months Completed Employment Employee Full Name: Last What position does this employee hold? Number of hours per week the employee worked? Employee Initial Start Date: What is the date of completion of 12 months full time employment for this employee? Has this employee been on leave, outside of regular vacation or sick time, in the last 12 months? If so, what was the time period? Name of Agency/Program: Was this position within Specialized Foster Care, or MHSA Funded? _____ Please explain. _____ Name of Authorized Agency Representative: Title: Address: City, Zip: Business phone #: Email address: I certify that the information I have given on this form is true and correct. I understand that purposefully providing false information on this form may lead to legal penalty and the forfeiture of stipend financial aid for the employee. Signature: DO NOT COMPLETE THIS SECTION – For MFT Stipend Program/Phillips Graduate Institute use only.

The information requested on this form is required for completion of the LAC DMH Stipend Contract Obligation and Employment Payback.

Date:

Please mail the form with original signatures to:

Jose Luis Flores, M.A. MFT Stipend Program Phillips Graduate Institute 19900 Plummer Street Chatsworth, CA 91311